**Maryland HealthChoice Waiver - Community Health Pilots**
**Frequently Asked Questions and Answers for the**
**Home Visiting Services Pilot**
*Released 6/7/17, Updated 6/20/17*

This document is a compilation of frequently asked questions (FAQs) and responses regarding the Maryland Department of Health and Mental Hygiene (DHMH) HealthChoice Waiver initiative: Home Visiting Services (HVS) Pilots. This document is a living document and will be updated as additional questions are received.

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## A. General FAQs

### 1. Overview, Timeline, and Contact Information

**a. What are the Maryland HealthChoice Waiver Community Health Pilots?**

*DHMH Response:* As part of the state of Maryland's HealthChoice §1115 Waiver, the Department of Health and Mental Hygiene (DHMH) is facilitating federal matching funds for two pilot programs: (1) Assistance in Community Integration Services (ACIS), for Medicaid enrollees who are high-risk, high-utilizing and either transitioning to the community from institutionalization or at high-risk of institutional placement; and (2) Home Visiting Services (HVS), which offers evidence-based home visiting to high-risk pregnant women and children up to age 2.

There is widespread evidence that socioeconomic factors significantly impact health outcomes. Social determinants of health have a particularly strong effect on vulnerable individuals, including the populations served under Maryland's Medicaid program. Coordinating health and social

services and addressing social determinants of health through a "whole-person" strategy has shown promise as a way to enhance health outcomes and lower costs. The Pilots are opportunities for communities to be able to clearly demonstrate if, in fact, providing expanded HVS and ACIS to the Maryland Medicaid population is a sustainable model that improves health outcomes and reduces healthcare costs among the target populations.

**b. Is there a specific email address for Community Health Pilot questions and comments?**

*DHMH Response:* Yes, you may direct your questions and comments to dhmh.healthchoicerenewal@maryland.gov

**c. If Lead Entities opt to not apply for Year 01 participation in the Community Health Pilots, may they apply later instead?**

*DHMH Response:* At this time, DHMH anticipates that it will offer a second round RFA next year. However, this decision is contingent upon first year award selections and the performance of Community Health Pilots.

**d. Where can I learn more about the content of the approved programs?**

*DHMH Response:* Please refer to the DHMH Community Health Pilots website at https://mmcp.health.maryland.gov/Pages/HealthChoice-Community-Health-Pilots.aspx.

Please also refer to the official websites of the approved evidence-based programs for the HVS Pilot:
Health Families America (Healthy Families America)
Nurse Family Partnership (Nurse Family Partnership)

**e. What are the key deadlines for launching the Home Visiting Services (HVS) Pilot?**

*DHMH Response:* The anticipated timeline is as follows:

| **Deliverable/Activity** | **Date** |
|---|---|
| Release Letter of Intent request for Community Health Pilots | May 10, 2017 |
| Letters of Intent due from Lead Entities to DHMH | May 24, 2017 |
| HVS Pilot Application Published by DHMH, FAQs released | June 7, 2017 |

| | |
|---|---|
| HVS Pilot Application Process Webinar and Review of FAQs | June 21, 2017, 1:30pm-3pm |
| HVS Pilot Applications due to DHMH | July 21, 2017 |
| Calls with applicants (clarification & modification discussions) | July 24-27, 2017 |
| HVS Pilot Award Notifications (expected, pending final CMS approval) | August 28, 2017 |

**2. Lead and Participating Entities**

**a. Who may apply to be a Lead Entity for the Pilots?**

*DHMH Response:* DHMH will accept applications for the Pilots from Local Health Departments, Local Management Boards, a consortium of entities serving a county or region consisting of more than one county or city, a federally recognized tribe, or a tribal health program under a Public Law 93-638 contracted with the federal Indian Health Services. Applicants will act as the Lead Entities on the project. Lead Entities will need to participate in the financing of the non-federal portion of medical assistance expenditures. Each Lead Entity must be able to provide the non-federal share of payment through an intergovernmental transfer (IGT). Lead Entities will also serve a critical role in providing leadership and coordinating with key community partners, such as Participating Entities, to deliver the programs.

**b. Are Departments of Aging, Social Services, or Local Management Boards eligible to be Lead Entities?**

*DHMH Response:* Each Lead Entity must be a local government entity, be able to provide the non-federal share of payment through an intergovernmental transfer (IGT), and manage required fiscal and contractual reporting. Lead Entities will be responsible for managing the Pilot relationship with DHMH and also required to provide leadership and coordination with key community partners to deliver the programs.

**c. Could you be more specific as to what is meant by coordination with MCOs?**

*DHMH Response:* A major goal for the Pilots is to increase coordination and provide appropriate access to care for the most vulnerable Medicaid beneficiaries. The Pilots are required to have key community partners (Participating Entities) participate in the Pilot. These Participating Entities should include organizations such as managed care organizations (MCO) and must have significant experience serving the target population within the participating geographic area.

Eligible Medicaid beneficiaries enroll in an MCO of their choice and select a primary care provider (PCP) to oversee their medical care. In addition to providing Medicaid-covered services to those enrolled in the MCO, an MCO has specific standards and responsibilities concerning the provision of care, including coordination and referral for certain services for pregnant and postpartum women and children with special health care needs.

Given the significant role that MCOs play in the care coordination role of Maryland Medicaid enrollees, DHMH mandates that Lead Entities establish appropriate links and communications with MCOs in any proposed Pilot application. Therefore, Pilot applications will require a description of how care coordination is to be implemented at the organizational and provider level, including the Participating Entity's responsibilities in relation to the Lead Entity and other Participating Entities.

**d. Can you tell us more what you are contemplating in regards to coordination with Administrative Care Coordination Units?**

*DHMH Response:* Lead Entities should include a description in their application as to how they will coordinate with ACCUs in the context of the HVS Pilot work.

**e. Will funding be distributed as grant funding to Lead Entities?**

*DHMH Response*: No. Community Health Pilot funding differs from a typical grant funding process. Applicants' funding assumptions will be derived from a "per home visit services rate" developed and proposed by the Lead Entity. Pilots must have a lead local governmental entity with the ability to fund fifty percent of total pilot costs through an intergovernmental transfer (IGT). Once DHMH receives the IGT from the local entity, the IGT will then be matched with federal dollars. This combined sum will then be disbursed to the Lead Entity to pay for home visiting services rendered.

**f. Do you anticipate the Lead Entities having to provide an annual independent financial audit to verify the source of the local funding?**

*DMHM Response*: All non-federal entities that expend $500,000 or more of federal awards in a year are required to obtain an annual audit in accordance with the Single Audit Act Amendments of 1996, OMB Circular A-133, the OMB Circular Compliance Supplement and Government Auditing Standards. A single audit is intended to provide a cost-effective audit for non-federal entities in that one audit is conducted in lieu of multiple audits of individual programs. Additionally, the Centers for Medicare and Medicaid Services (CMS) has program monitoring and reporting requirements for the HealthChoice §1115 Waiver as defined in the Pilot Special Terms

and Conditions. Pilots must report to DHMH in accordance with the requirements contained in the Special Terms and Conditions. Each approved Pilot's reporting requirements will be comprehensively defined in its agreement with DHMH.

**g. Does the State expect a particular approach to referring individuals to these programs or do the applicants have leeway to propose their own?**

*DMHM Response*: In the Request for Applications (RFA), DHMH asks the applicants to describe their proposed process of identifying and prioritizing eligible participants, in addition to necessary referral mechanisms and methods.

**h. Is a Home Health Agency considered a Lead or Participating Entity?**

*DMHM Response*: No, a Home Health Agency would not be considered for a Lead Entity. Please reference Section A.2.a for the requirements for a Lead Entity. A Home Health Agency could be considered as a Participating Entity depending on the role it may play. For the HVS Pilot, if a Lead Entity is considering a Home Health Agency as a direct service provider, the Home Health Agency must be HFA or NFP accredited.

**i. Are only the Lead Entities required to complete the Letter of Intent?**

*DMHM Response*: Yes, only the Lead Entities are required to complete the Letter of Intent (LOI).

**j. Can you provide an example of Lead Entities besides the Local Health Department?**

*DMHM Response*: In addition to Local Health Departments, other Lead Entities may be Local Management Boards, a consortium of entities serving a county or region consisting of more than one county or city, a federally recognized tribe, or a tribal health program under a Public Law 93-638 contracted with the federal Indian Health Services.

**k. What are the expectations for demonstrating execution of the partnerships with other entities for purposes of administering the Pilots?**

*DHMH Response: T*he Lead Entity is required to include a letter of commitment from each of the Participating Entities in its application. Each letter of commitment must indicate the role that the Participating Entity will serve throughout the planning, implementation, and evaluation of the Community Health Pilot, along with the Participating Entity's capacity to perform proposed responsibilities. If and when the application is approved and funded, the Lead Entity will be responsible for executing all necessary contracts and data use agreements with each Participating Entity.

**3. Finance**

**a. Can state grant dollars (that are not federal dollars) be used as a match for the IGT process?**

*DMHM Response*: This depends on several factors. Funds used for the non-federal portion may be local tax dollars, local core funding dollars, or non-restricted funding from the state. Non-restricted funding are monies available without any restrictions, such as restrictions in regard to specific programs or population to be served. There will be no state Medicaid contribution for the Pilot program.

The local share of funds (non-federal portion) must not be used to match any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Social Security Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval and CMS may review the sources of the non-federal share of funding for the demonstration at any time.

**b. What is the possibility of new funding after the 4.5 year Pilot period? Will Pilots need a financial sustainability plan for the post-Pilot years?**

*DHMH Response*: Funding beyond this waiver renewal period is unknown. DHMH expects that applicants for the Pilots to explain how the Pilot funding will align with their long term goals. This will include addressing the needs of the Pilot target population through expanded service delivery, and the proposed method of program and financial sustainability. The results of the Pilot evaluation will inform programmatic decisions for future waiver renewal applications.

**c. Can state core dollars be used as a match?**

*DHMH Response*: This depends on several factors. Public health state core dollars may be contributed as the local match unless those core funds are currently used to provide the match for another federal program, such as Title V funding or Medicaid funding (e.g.: Expanded Administrative Care Coordination). The payments must not offset payment amounts otherwise payable by the local entity for beneficiaries nor supplant provider payments from the local entities. Lead Entities should confer with the State funder of the core funds or other funding through the state to ensure compliance.

During application evaluation period, DHMH will review the identified sources of the local match for appropriateness and provide consultation, to the Lead Entity, as needed. Furthermore, all sources of the non-federal share of funding and distribution of monies involving the federal match are subject to CMS approval.

**d. Will DHMH be limiting the number of grant awards made (e.g., to two, three, four consortia)?**

*DHMH Response*: DHMH does not anticipate putting limits on the awards to be made. At this time, DHMH does not yet know how many applicants will apply, the proposed funding amounts applicants will be able to provide as non-federal share, and other relevant information needed to make that determination.

**e. Is the local match an In-Kind or Cash Match?**

*DHMH Response*: The local matching funds must be a cash match comprised of an electronic transfer of funds to DHMH.

**f. Will DHMH be providing a template for invoicing under the Pilot?**

*DHMH Response:* Yes, DHMH will provide a template for invoicing to each approved Lead Entity.

**4. Evaluation**

**a. Will DHMH contract with outside entities (e.g., local universities) to conduct Pilot program evaluation?**

*DHMH Response*: Yes, DHMH anticipates working with its evaluation partner, The Hilltop Institute at UMBC, and may partner with other evaluation entities that are yet to be determined. DHMH also expects that Pilots will conduct self-monitoring, evaluate their activities and performance, and report the results of such evaluations to DHMH.

**b. Will there need to be data use agreements between the awardees, the MCOs, Hilltop, and DHMH? Will these need to be in place prior to implementation?**

*DMHM Response*: Yes, final approval of any application will be subject to the Lead Entity's mandatory agreement to the forthcoming Inter-Agency Agreement and Data Use Agreements, which will govern the Lead Entity's assurances to provide the required data elements, as well as the exchange and utilization of the data involved in the Community Health Pilot.

## B. FAQs Specific to Evidence-Based Home Visiting Services (HVS) Pilot Program

1. **Target Population**

**a. Who would be eligible for home visiting services in this program?**

*DHMH Response*: The intent of the HVS Pilot funding opportunity is to expand evidence-based home visiting services to Medicaid eligible high-risk pregnant women and children up to age 2. To participate in HVS Pilot, the recipient must be a Medicaid beneficiary. The HVS Pilot must align with at least one of two evidence-based models that focus on the health of pregnant women and children up to age 2: Nurse Family Partnership (NFP) or Healthy Families America (HFA).

As provided in the HVS Pilot RFA, HVS Pilot applicants could establish primary or secondary target groups as a way to prioritize the highest risk populations that applicants have identified as being the most urgently in need of Pilot services:

| Primary Risk Factors | Secondary Risk Factors |
|---|---|
| ● Adolescent ≤ 15 years<br>● Late Registration > 20 wks<br>● Abuse/Violence<br>● Alcohol/Drug Use (may target by substance)<br>● Less than 1 year since last delivery<br>● History of fetal/infant death<br>● Non-compliance | ● Disability (mental/phys/develop)<br>● Less than 12$^{th}$ grade education or no GED<br>● Lack of social/emotional support<br>● Housing/environmental concerns<br>● Smoking/tobacco use |

**b. If the HVS Pilot is limited to Medicaid eligible groups, how will eligibility for undocumented postnatal women with Medicaid eligible children be determined?**

*DHMH Response:* The HVS Pilot is designed to provide evidence-based home visiting services for high-risk Medicaid enrolled pregnant women and children up to age two. Undocumented pregnant women are ineligible to enroll in Medicaid, and services other than labor and delivery cannot be paid by Medicaid. Thus, they are not eligible to participate in the HVS Pilot.

**c. Will the Lead Entity and its chosen local partners be required to identify which specific Medicaid beneficiaries have received HVS funds through the Community Health Pilot?**

*DHMH Response:* Yes, Lead Entities must accomplish this by providing either (1) a Medicaid identification number or (2) a combination of the beneficiary's first and last name, birth date, and Social Security number. Prior to providing services, a beneficiary's Medicaid eligibility must be verified through the Maryland Medicaid Eligibility Verification System.

**d. Are HVS Pilot payments limited to Medicaid beneficiaries (at initial enrollment and for the duration of their enrollment, even if these beneficiaries lose Medicaid eligibility)?**

*DHMH Response:* No, Pilot payments are limited to Medicaid beneficiaries only as long as they are actively enrolled in Maryland Medicaid. When pregnant mother initially enrolls in the HVS Pilot, the mother must already have been enrolled in Medicaid. This mother will be Medicaid eligible for up to 60 days after she gives birth. However, if the mother loses Medicaid eligibility but the index child continues to be enrolled, the child is considered being served. If that child is eligible for Medicaid, both the mother and the index child may continue to participate in the program.

**e. Can a family enroll after a pregnancy has concluded if there are still children under the age of 2 in the family?**

*DHMH Response:* HVS Pilot applicants must follow the program model's guidelines. For NFP, enrollment must occur before the 28th week of pregnancy. For HFA, enrollment must occur before the child turns 3 months old. A child must be enrolled by these cut-off points in order to receive HVS Pilot services.

**f. If beneficiaries are currently enrolled in an evidence-based home visiting program, such as HFA, can they partake in the HVS Pilot at the onset of the Pilot's implementation or do beneficiaries need to be newly enrolled once the HVS Pilot begins?**

*DHMH Response:* Current participants in evidence-based HVS are not eligible to be enrolled in the HVS Pilot. The HVS Pilot opportunity is intended to expand services to additional clients who are Medicaid beneficiaries. The act of moving a currently enrolled HFA client to the newly expanded HVS Pilot program would be considered supplanting and is not allowable under Federal rules.

2. **Services**

**a. Would work outside of the typical Healthy Families America (HFA) model have to be covered by another non-federal funding source? For example, for Healthy Families - MIECHV program, a team may consist of a support worker with a public health nurse. Under this model, the grant could cover the HFA support worker, but would DHMH have to cover the public health nurse**

**with non-federal funding?**

*DHMH Response*: Pilot funding is only available for direct services delivery and based on a "per home visit services rate", which is to be developed and proposed by the Lead Entity. HVS Pilot funded services must align with at least one of two evidence-based models that focus on the health of pregnant women: NFP or HFA. Applicants should take into consideration that working outside of the HFA or NFP programs may alter the ability to evaluate the fidelity of these models. Any additional services which are outside of the NFP or HFA models may not be funded using HVS Pilot award funds.

**b. How can applicants get in touch with a HVS provider in their area, or find out about HVS activities in their jurisdiction, including those related to MIECHV?**

*DHMH Response:* A list of currently HFA accredited programs by jurisdiction is noted below in 2.e. or upon request to mdh.healthchoicerenewal@maryland.gov .

**c. Is the HVS Pilot an opportunity to enhance and expand upon home visiting services?**

*DHMH Response:* Yes, the HVS Pilot is an opportunity to expand upon home visiting services. The HVS Pilot was developed in response to local jurisdictions' requests for a funding path to expand evidence-based home visiting services to Medicaid eligible high-risk pregnant women and children. The HVS Pilot is an opportunity for communities to clearly demonstrate if, in fact, providing expanded evidence-based HVS using Medicaid resources is a sustainable model that improves health outcomes and reduces healthcare costs among the target populations.

**d. Is there a list of Local Health Departments that are planning to apply with which applicants may collaborate?**

*DHMH Response:* DHMH has received Letters of Intent to apply for the HVS Pilot from interested applicants. However, since the HVS Pilot is being offered as a competitive funding opportunity, DHMH is unable to supply the names of the interested entities at this time. Nevertheless, in order to facilitate collaboration, DHMH has included below the jurisdictions that currently operate an NFP or HFA program. DHMH recommends that entities interested in collaborating should reach out to the Local Health Officer in the appropriate jurisdiction. DHMH will provide a public announcement of Pilot awardees after applications have been approved, Lead Entities have been notified of its receipt of an award, and all parties have executed the requisite legal agreements.

**Current Evidence-based Home Visiting Programs (HFA and NFP*) in Maryland by Jurisdiction**

| Jurisdiction | Agency | Current Status |
|---|---|---|
| Allegany | Health Department | Affiliated |
| Baltimore County | Health Department | Accredited |
| Baltimore City* | Family League | Accredited |
| Calvert County | Public Schools | Accredited |
| Charles County | Center for Children | Accredited |
| Dorchester | Health Department | Accredited |
| Frederick | Mental Health Association | Accredited |
| Garrett | Health Department | Accredited |
| Harford | Health Department | Affiliated |
| Howard | Howard General Hospital | Accredited |
| Lower Shore (Somerset) | Eastern Psych Association | Accredited |
| Mid Shore | Health Department | Accredited |
| Montgomery | Family Services | Accredited |
| Prince George's | Dept. Family Services | 2 Sites Accredited; 1 site Affiliated |
| Washington | Health Department | Accredited |
| Wicomico | Health Department | Accredited |

**e. When DHMH says "services not otherwise covered", how might that work with developmental and maternal depression screening? Can those be part of a HVS bundled payment, per visit rate?**

*DHMH Response:* Some types of screening are inherent components of the HFA and NFP evidence-based models of practice, as defined by HFA and NFP. Pilot funding is available for direct services delivery only and based on a "per home visit services rate." If the type of developmental and depression screenings fall within HFA and NFP "*Description of Services*" outlined in STC 29: Attachment D, such services are included in the "per home visit services rate".

**f. How do HFA and NFP compare to the Residential Services Agencies?**

*DHMH Response:*
Maryland describes Residential Services Agencies as: *An agency that provides supportive home care services, for example, assistance with ADL's and/or housekeeping services, some nursing services, and may provide one or more home care service such as provision of oxygen or medical equipment such as wheelchairs, walkers and hospital beds.*

According to the Centers for Medicare and Medicaid Services and the Health Resources and Services Administration, evidence-based home visiting services such as HFA and NFP support pregnant women and families with young children by assisting them in accessing services and learning the necessary skills to raise children who are physically, socially, and emotionally healthy and ready to learn. These programs improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development.

**g. What happens next if home visiting services needs to continue after children turn two and age out of the pilot program?**

*DHMH Response:* DHMH would expect the Lead Entity to coordinate with the family and Participating Entities such as the beneficiary's MCO to identify the family's specific needs and be transition the family to other programs or services within the jurisdiction that could support the family's need.

**h. How will MCOs and LHDs know who are applying for the HVS Pilot?**

*DHMH Response:* DHMH anticipates that once it has received the applications, it will work with its Public Health partners and Local Health Officers to determine the best way to communicate with MCOs and respond to requests to collaborate. DHMH will provide a public announcement of Pilot awardees after applications have been approved, Lead Entities have been notified of its receipt of an award, and all parties have executed the requisite legal agreements.

i. **Is care coordination considered a direct provision of service?**

*DHMH Response*: Care coordination falls within the context of evidence-based HVS models of practice, as defined by HFA and NFP. If the type of care coordination this question poses falls within HFA and NFP *Description of Services* outlined in STC 29: Attachment D, such care coordination services are included in the "per home visit services rate."

j. **Please provide examples of other services that might be considered to be funded. For instance, would supportive services, such as nutrition counseling, that fall outside of the HFA model but would be a potentially important supportive service be funded?**

*DHMH Response*: Only services outlined in HFA and NFP *Description of Services* STC 29: Attachment D are eligible for Pilot funding.

k. **Can applicants reach out to accredited providers outside the county? For example, local procurement regulations may require contracts to be competitively bid. If an applicant is limited to the one provider listed in the applicant's county, the applicant needs to have this in writing from DHMH in order to executive a sole source contract.**

*DHMH Response:* Lead Entities should follow local procurement rules and policies.

l. **The letter of intent instructions specify that services may be provided to children up to age two. However, HFA national accreditation requires services until age three. Will the HVS Pilot program be limited to serving children under age two?**

*DHMH Response:* Yes, the HVS Pilot program will be limited to serving children under age two.

m. **Our understanding is that the DHMH MIECHV Program will allow its staff to be supervised by staff funded by another source, as long as data is shared with the MIECHV Program. Will the HVS Pilot Program similarly allow its Pilot funded staff to be supervised by staff funded by another source?**

*DHMH Response:* Yes, this will be permitted

**3. Finance**

a. **Given that federal funds are involved, do federal policies and procedures apply, such as DHMH MIECHV?**

*DHMH Response*: Yes, Medicaid, as well as other program integrity federal rules and regulations, apply.

**b. Will HVS Pilot funding be limited to the counties currently using eligible evidence-based home visiting programs?**

*DHMH Response*: Lead Entity applicants to the HVS pilot program is open to any county that is interested in participating and can produce the non-federal portion of funding for HVS service delivery. The intention of the HVS pilot is to expand HVS service delivery through HFA or NFP programs. This may be accomplished either through 1) an expansion of existing county programs, 2) if counties are able to leverage non-Pilot funds for start-up costs of a new HFA or NFP program, then counties could use the Pilot funds along with the required match to pay for HVS service delivery through either a governmental entity or a contracted HFA or NFP program(s), or 3) a county may enter into a partnership with one or more counties with existing HVS programs. Given the time, effort, and cost of initiating a new HFA or NFP accredited program, a qualifying Lead Entity may want to consider partnering or contracting with HFA or NFP programs that are already in operation.

**c. Can Community Health Pilot funds be used to supplement or offset the cost of designing one of the evidence-based programs (i.e., Health Families America; Nurse Family Partnership)?**

*DHMH Response*: No, Pilot funding is available for direct services delivery only and based on a "per home visit services rate" proposed by the Lead Entity. There is no start-up funding available in this Pilot demonstration. DHMH is facilitating this matching federal funding opportunity in response to local programs who have expressed the need for expansion of evidence-based HVS. Funds are not available to build infrastructure or address start-up costs, such as program licenses and training. Lead Entities may have other resources that could be used to build capacity to start-up the program of their choice (NFP or HFA).

**d. Is it permissible to assign already existing staff to provide HVS to eligible Medicaid beneficiaries participating in the Community Health Pilot waiver program?**

*DHMH Response*: This depends on several factors. If funding of the proposed home visiting services by the existing staff is already being matched by federal funds, whether this is done by a cost allocation plan or another source of federal match or grant support, then such duplicative assignment of already existing staff is not permissible. Funding is for expansion of services only. Thus, funding cannot be used to supplant, "double dip", or replace existing services.

**e. May the Lead Entity and its chosen partners leverage MIECHV funds in the context of this Community Health Pilot? If so, how?**

*DHMH Response*: More detail is required to respond to this question. Questions concerning the permissibility of specific scenarios with regards to using and/or leveraging MIECHV funds in the HVS Pilot context may be directed to mdh.healthchoicerenewal@maryland.gov.

**f. Can the Pilot funding be applied to existing Healthy Families America accredited programs? If so, can existing local funding for an HFA program be used to satisfy the match requirement for the HFA program if the program enrollment is either expanded or not expanded under the proposal? In other words, is there a local funding supplantation prohibition?**

*DHMH Response*: Supplantation of existing funds and services is prohibited. Pilot funding is strictly for expansion of HFA or NFP accredited programs. Local funding already allocated for the continued operation of an existing HFA or NFP program may not be used to satisfy the local match requirement for the expansion. Existing local funding can be used to achieve the local match requirement, as long as it is from a permissible source, does not supplant, and meets the necessary requirements for an IGT.

**g. How long will it take for payment to be disbursed back to the Lead Entity after the Lead Entity has submitted its request for payment?**

*DHMH Response*: At this time, DHMH cannot provide the exact length of the time that it will take for payment to be disbursed. This is a Pilot with new funding parameters and will face the limitations involved with the utilization of MMIS. Specifically, DHMH will be unable to have claims submitted through MMIS and so Pilot Lead Entities will have to manually claim for services from DHMH instead. Lead Entities will be paid on a quarterly basis and will be required to provide the local funding match via an IGT before receiving complete payment for services rendered.

**h. Can modifications be made to the cost of project in the second year of implementation? For example, if a site provides more billable visits than initially estimated, can that be adjusted in the second year?**

*DHMH Response*: Once the Year 1 project budget for the Lead Entity is approved, this Year 1 budget may not be increased at any time during Year 1. However, DHMH expects that there may be adjustments to the proposed project budget for Year 2 based on Year 1 experience, and also based on availability of Lead Entity funding to meet the local match requirement. Proposed adjustments to the project budget for Year 2 will be considered in the context of DHMH's review of the Year 1 annual report; the proposed Year 2 work plan, Year 2 unit rate, Year 2 operating budget, and Year 2 budget justification; and the proposed sources of the Year 2 local match.

**i. Can a portion of local funds be private, non-profit philanthropic dollars from a foundation?**

*DHMH Response*: This depends on several factors. This may potentially be permissible, as long as the restrictions that accompany the philanthropic grant are fully upheld, the money is otherwise unencumbered, and the funding sources are from an allowable matching fund source. In the case of a restricted grant, whether or not it may be applied to support expansion of home visiting services depends on the terms of the restrictions that come with the award. In contrast, non-restricted philanthropic funding is usually a grant made to the general operating fund of the Lead Entity without any restrictions, such as restrictions in regard to specific program or population to be served. Use of non-restricted philanthropic funding is typically permissible. DHMH reserves the right to evaluate funding sources at any stage of the Pilot, whether during the review of the application for funding or at a later point in time when project-relevant philanthropic funding is received and reported to the DHMH by the Lead Entity.

**j. If a program is being reimbursed by number of home visits, what should Lead Entities do if they have family that is on Level X where the Lead Entity still needs to engage families for approximately for three months and often no home visit has taken place? Would programs still be reimbursed?**

*DHMH Response*: Pilot funding is for direct services delivery only and based on a "per home visit services rate" for Medicaid eligible high-risk pregnant women and children up to age 2. Services to this population that are within the parameters of the HFA and NFP "*Description of Services*" outlined in STC 29: Attachment D are eligible for reimbursement at a "per home visit services rate".

**k. What kind of per visit rate are you expecting to see in the proposals?**

*DHMH Response*: As described in the following excerpt from STC 29: Attachment D (Appendix B), allowable components that make up a home visiting services rate (per unit cost):

*"...The unit cost that will be based on such things as, estimated salary costs, travel cost, reporting costs, and other reasonable and necessary expenditures divided by the number of expected number of visits. The expected number of visits will be based on the model, the number of beneficiaries to be served, and the number of home visitors. DHMH will evaluate the reasonableness of the unit cost and total payment. DHMH anticipates that the initial quarterly payments will be prospective, and thereafter retrospective based on the Lead Entity's actual HVS services rendered. In turn, DHMH anticipates that the HVS provider will invoice the Lead Entity monthly or quarterly for home visits provided to a specific Medicaid beneficiary based on the Lead Entity and HVS provider's contractually agreed upon payment schedule. Lead Entities are expected to submit a budget proposal and narrative that reflects average expected evidence-based home visiting frequency and intensity, taking into account the potential for variations, that*

*is, accommodating for those few cases that may require more intense visits."*

DHMH recognizes that developing a per home visit rate may be challenging given that many existing evidenced-based home visiting programs are not currently structured using a per-visit unit cost. Following release of this RFA, additional individualized technical assistance will be offered to interested entities on home visiting rate development. HVS Pilot applicants should indicate interest in participating in this individualized technical assistance offering for rate development in their Budget Narrative.

A discussion of cost and rate development methodologies for evidence-based HVS programs may be found in the Mathematica Policy Research study "Cost of Early Childhood Home Visiting: An Analysis of Programs Implemented in the Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment Initiative." Additional resources that may be useful for HVS rate development will be posted on the DHMH website and shared with interested entities as they become available.

CMS, as well as DHMH, must review and approve any proposed unit rate before it goes into effect.

**l. Is the per visit fee to be established for each application or will it be applied state-wide?**

*DHMH Response:* The per home visit rate is to be established by each Lead Entity. Please refer to Section 3k. above for detail.

**m. Would it be possible to use a different method to show CMS the local match for DHHS? For example, in the case of DHR (where they are claiming state funds), we send them a monthly download of all of our expenditures showing exactly where those dollars were spent. We do a conversion to put everything in terms of the state chart of accounts, and the state then uploads this into their own financial system. It then feeds their FFP claim. Is there some flexibility around this to avoid the additional steps of sending the funds to the state first?**

*DHMH Response:* No, Pilot funding is for direct services delivery only and based on a "per home visit services rate" for Medicaid eligible high-risk pregnant women and children up to age 2 developed and proposed by the Lead Entity. Each individual participant and service must be accounted for at Medicaid enrollee level. Funding is not based on a state chart of accounts and so the method described above is not permissible. CMS requires that the State and locals follow the IGT process. Please refer to application Section 6: Budget Plan and Financing Structure of the application for a description of the permissible financial structure and the accompanying funding flow diagram.

**n. In future years, will funding be available for jurisdictions who want to start an evidence-based program in lieu of a vendor?**

*DHMH Response:* This depends on several factors. Pilot funding, now and in the future, is available for direct services delivery only and based on a "per home visit services rate" for HFA or NFP that is to be developed and proposed by the Lead Entity. There is no start-up funding to this Pilot demonstration. Funds are not available to build infrastructure or to address start-up costs, such as program licenses and training. Any additional services which are outside of the scope of NFP or HFA direct service delivery may not be funded using Pilot award funds. Lead Entities may have other resources that could be used to build capacity to stand-up the program of their choice (NFP or HFA).

**o. Can the local match be dollars that are used to fund existing staff who would then be working within the new evidence-based practice model? Can local dollars be used to help with start-up activities?**

*DHMH Response*: No, there is no start-up funding to this Pilot demonstration. Funding is strictly based on a "per home visit service rate," which is to be developed and proposed by the Lead Entity. DHMH is facilitating this matching federal funding opportunity in response to local programs that expressed the need for expansion of evidence-based home visiting services. Funds are not available to build infrastructure or to address start-up costs, such as program licenses and training. Any additional services which are outside of the scope of NFP or HFA direct service delivery may not be funded using Pilot award funds. Lead Entities may have other resources that could be used to build capacity to startup the program of their choice (NFP or HFA).

**p. What is the total funding available and the annual funding available for the HVS Pilot?**

*DHMH Response:* CMS approved the Pilots for a 5-year waiver renewal period. The HVS Pilots have an effective date of July 1, 2017, so the HVS Pilots will run over a 4.5 year period. For the HVS Pilot, up to $2.7 million in matching federal funds are available annually. When combined with the local non-federal share, HVS Pilot expenditures may total up to $5.4 million annually.

**4. Evaluation**

**a. Will program data need to be entered into "ETO" or other data systems, such as like the DHMH MIECHV program, in addition to PIMS, as is required by HFA?**

*DHMH Response*: Lead Entities will be required to provide DHMH will specific program and individual level data. This may be in the form of a data extract from an existing data system or the creation of a spreadsheet. DHMH expects that HVS Pilot awardees will have in place or contract for a Performance Management System with the capabilities for data collection, record keeping, data sharing, data analysis, reporting and demonstrating quality improvement, in

accordance with HVS Pilot reporting requirements, as outlined in the STC: Attachment D, RFA, and any other applicable DHMH guidance. In the RFA, HVS Pilot applicants must indicate which system(s) they are using. Medicaid and Public Health staff are collaborating to seek future alignment opportunities with existing data systems and the HVS Pilot requirements.

**b. What goals/outcomes/targets does DHMH expect for the HVS Pilots?**

*DHMH Response*: The goal of the HVS Pilot is to create opportunities for communities to be able to clearly demonstrate if, in fact, providing expanded HVS services within certain high-risk Medicaid populations in Maryland is a sustainable model that improves health outcomes and reduces healthcare costs among the target populations. Pilots will be required to report measures and outcomes as outlined in the RFA.

**c. Will the data requirements for HVS be comparable to or different from the MIECHV data requirements?**

*DHMH Response*: To the extent possible, DHMH has made attempts to align data requirements for the HVS Pilot with those for the MIECHV program. Currently, 21 out of 24 Maryland county health departments (including Baltimore City) offer evidenced based home visiting services through the Federal Home Visiting Program (MIECHV) administered by HRSA. MIECHV has established multiple data collection elements of which DHMH has adopted a subset for the purposes of HVS Pilot funding and evaluation. The decision for modifying data collection elements for the HVS Pilots is based on several factors. Primarily, the HVS Pilots are designed to demonstrate evidenced-based HVS value specific to the Medicaid program, to make certain all Medicaid funding and reporting requirements can be met, and to align with goals of the CMCS Maternal and Infant Health Initiative and CMS's Child Core Set Measures.

**d. What data collection support will be offered to sites that are not MIECHV funded?**

*DHMH Response*: Additional guidance is forthcoming regarding data collection and reporting. At this time, and due to the limitations of a standardized HVS or Medicaid data collection requirements and systems, Lead Entities will be required to provide DHMH will specific program and individual level data. This may be in the form of a data extract from an existing data system or the creation of a spreadsheet. DHMH expects that HVS Pilot awardees will have in place or contract for a Performance Management System with the capabilities for data collection, data sharing, reporting and demonstrating quality improvement in accordance with HVS Pilot reporting requirements, as outlined in the STCs: Attachment D, the RFA, and any subsequent DHMH guidance. The RFA asks HVS Pilot applicants to indicate which system(s) they are using. Medicaid and Public Health staff are collaborating to seek future alignment opportunities with existing data systems and the HVS Pilot requirements.